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| **Nursing Assistant Training Program Student Record** | | | |
| **Program Name:** | | **Program Number:** | |
| **Directions** | | | |
| Use the program evaluation methods to complete the student record form below. All components/ criteria included in program evaluation methods should be reflected on this form. Programs maintain student files for a minimum of five (5) years, per [WAC 246-841A-455(2)](https://app.leg.wa.gov/WAC/default.aspx?cite=246-841A-455&pdf=true) | | | |
| Student Information | | | |
| **Student Name:**  **Enrollment** **Dates:** | | | |
| Test Results | | | |
| **Test Date** | **Test Number or Title** | | **Grade or Percentage** |
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| Passing Criteria/Standards | | |
| **Course Component** | **Criteria/Standard** | **Met/Not Met** |
| **Class/Theory** |  |  |
| **Skills Lab** |  |  |
| **In-Facility Clinical** |  |  |
| **Overall** |  |  |
| Course Outcome | | |
| ☐ Passed ☐Failed ☐ Withdrew ☐ Incomplete | | |
| ☐ Check if this is a repeat attempt to pass the class. | | |
| Comments | | |
| Use this section for comments. If applicable, explain failure, dismissal, or standards not met. | | |
| Program Director’s Signature | | |
| **Program Director’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date: \_\_**  **Program Director’s name:** \_\_\_\_\_\_\_  **Please print, sign, and return via email to** [**WABONNursingAssistantsED@doh.wa.gov**](mailto:WABONNursingAssistantsED@doh.wa.gov) | | |